OUT OF STATE PLACEMENT
LIST OF ATTACHMENTS

- Out of State Placement Request Checklist and Placement Request Guideline Form
- Support Statement

PROCEDURES FOR OUT-OF-STATE PLACEMENTS

Out-of-State (OOS) Placement Request Checklist

Prior to filling out the referral procedure form, review the checklist to see that all in-state resources have been exhausted and that you have all the information and documentation necessary to complete the referral packet.

Check the appropriate answer. If the answer is N, explain.

1.) Client Information			
♦ Unique ID or ID #		Y	N
♦ CAFAS score		Y	N
♦ NC-SNAP Score		Y	N
♦ Medicaid number	N/A	Y	N
♦ Life Chart	N/A	Y	N
♦ parent or legal guardian involvement		Y	N
2.) Integrated Service Plan revision		Y	N
3.) Crisis Plan		Y	N
4.) IEP	N/A	Y	N
5.) Diagnostic categories & rule/out diagnoses		Y	N
6.) Medications (including those for medical purposes)		Y	N
♦ dosages/targeted signs and/symptoms		Y	N
♦ involuntary movement scale		Y	N
♦ behavioral concerns/issues	N/A	Y	N
7.) Psychosocial history		Y	N
♦ addendum	N/A	Y	N
8.) Treatment Summary		Y	N
♦ current clinical treatments/interventions identified		Y	N
♦ placement history		Y	N
9.) Current Residence/needs/effectiveness		Y	N
10.) Other supporting information	N/A	Y	N
♦ documentation	N/A	Y	N
11.) All applicable in-state resources explored		Y	N
♦ facilities/ level/ denial dates/reasons/appropriateness	N/A	Y	N
♦ wait list time documented	N/A	Y	N
12.) Level of Care defined by appropriate criteria		Y	N
13.) Alternative plan to OOS placement		Y	N
14.) Discharge plan		Y	N
15.) Step down plan for in-state services		Y	N
16.) Funding source(s) Medicaid/CTSP/ room & board		Y	N
17.) Signed acknowledgment/support statement by			
♦ Child and Family Team and the Area Director			
♦ Community Collaborative and the Area Director (CTSP youth)	N/A	Y	N
18.) Information sent to		Y	N
♦ the OOS Referral Packet to the State Office		Y	N
19.) Checklist completed and included with referral packet		Y	N

Placement Request Guideline Form:

- Read the guidelines and form carefully **as procedures have changed and are effective immediately.**
- Type the form (the form is available electronically--see the included list of web sites).
- **Current** is indicative and descriptive of the youth's present level of functioning.

Complete the following and attach the supporting documentation.

1. Client Information:

- First Name/Last Initial/ Unique ID & or ID #:_____ ___ _____
  (Enter the score, number or check if available)
  - CAFAS score __ NC-SNAP score_____ Life Chart ____Medicaid number_____
  - Identify how the parent or legal guardian is involved _____

2. Integrated Service Plan (include revised goals and outcomes on return to in-state services):

3. Crisis Plan

4. IEP (when appropriate and to include educational goals / outcomes during the OOS placement):

5. Current Diagnosis (Include Rule/Outs-Use DSM IV Criteria):

I: _____
II: _____
III: _____
IV: _____
V: _____

6. Medications and Targeted Signs/Symptoms (Current medications: target signs / symptoms/ behaviors--include dosages):

♦ **Medications**	**Dosage**	**Signs/ Symptoms /Behaviors**
Ex. Resperdal Tegretol	2 mgs Day 200mgs. BID	Hearing voices , clear thinking Reduce impulsivity, aggressive behaviors

- **If prescribed an anti-psychotic medication** include an abnormal involuntary movement scale (ex. AIMS)
- **Behavioral Concerns and Issues:** (relate to the identified diagnostic criteria)

_____
_____
_____

7. Psychosocial History (if more than a year old, include an addendum update).

8. Treatment Summary includes documentation that supports the DSM-IVTR multiple axes:

- **List** and document (summaries, assessments, recommendations and evaluations for all specialized therapies or interventions including but not limited to family/individual therapy, neurological [seizure disorder / TBI], assessments for MR/DD [a standardized cognitive measurement scale such as the WISC-R or Stanford Benet, adaptive measurement scale such as the Vineland, and a functional analysis [to determine the etiology of problem behaviors] and psychiatric evaluations. If sexual offender behavior is identified, include specifics & dates of the offense(s), adjudication date, offender's evaluation & a risk of

re-offending checklist. If substance abuse is identified, use assessment tools such as tools from the Majors Program or the Treatment Improvement Protocol Series (TIPS).

_____
_____
_____

Placement history:

Dates: Admission / Discharge	**Residential**	**Hospitalizations**

9. Identify current residence and needs not being met: Residence: _____

Needs	**Explain How An OOS Facility Will Provide *More Effective* Treatment**

10. Other information: support need for OOS placement (i.e. dated, documented incidences [school, residential], police, etc.

_____
_____
_____

11. Explore All Applicable In-State Resources (consult with Regional Service Managers, C & F Team and the Community Collaborative (if utilizing CTSP funds.) This includes:

- applications to all appropriate in-state facilities according to the requested level i.e. PRTFs or Level IV. (If the facility is deemed inappropriate, **explain.** Include facility denial documentation. Add rows as necessary.)

Facility/Level	**Denial Date**	**Denial Reason(s)**	**Pending Date**	♦ **Inappropriate / Explain**

12. Identify the Level of Care Needed:

- **Level IV** (use Level D **Initial** Criteria- see appropriate attachments):

  _____
  _____

- **PRTF:** (use the Medicaid PRTF service definition, **admission** criteria--see appropriate attachments.):

  _____

13. Identify an alternative plan should OOS placement not be possible (include residential and treatment interventions--be specific):

_____
_____
_____
_____

14. Discharge Plan:
Level IV (*Discharge Criteria* for Residential Treatment - Secure--see appropriate attachment):

_____
_____
_____

PRTF (use the PRTF *Discharge* Criteria-see attachment):

_____
_____
_____

15. Step Down Plan for In-State Residential Services & Treatment (be specific- identify residence, services, family/legal guardian involvement).

_____
_____

_____
_____
_____

16. Funding source(s) for Treatment and Room & Board (CTSP, Medicaid, DSS, other):

_____
_____
_____

17. Signed Acknowledgment/support statement :

- Child & Family Team and Area Program Director (attachment).
- Community Collaborative and Area Program Director (CTSP youth) (attachment)

18. Submit:

- OOS Placement Referral Packet to the State Office CFS Section

19. Complete the checklist and include with the referral packet.

Area Program: _____

CTSP Coordinator / Case Manager Supervisor: _____ Phone: _____

Case Manager: _____Phone:_____

Date Submitted: _____

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3015 Mail Service Center • Raleigh, North Carolina 27699-3015
Tel 919-571-4900 • Fax 919-571-4878
Michael F. Easley, Governor
Carmen Hooker Odom, Secretary
Richard J.Visingardi, Ph.D., Director

Out-of-State Placement Acknowledgement/ Support Statement

Area Program/Local Management Entity: _____
Client UID/ID Number: _____
Client Medicaid Number: _____
Date: _____

I am involved in the planning process for the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services", through the Child and Family Team and / or the Community Collaborative meetings. I agree that all In-State resources are exhausted and all requested documentation is included in this referral packet.

By signing this statement, the Area Program / Local Management Entity agrees to adhere to the Policies and Procedures of the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services" document.

Area Program Director: _____
Child and Family Team Representative: _____
Community Collaborative Representative: _____

4/01/2002 Out-of State Support Statement/CFS Section